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ABSTRACT

The historical and evolutionary development of the Tazwood Center for Human Services (Illinois) is traced, with a particular emphasis on describing administrative interventions which alleviate excessive stress and strain in the system and provide for growth experiences that prevent stagnation among the staff. The materials presented focus on the key elements which contribute to the viable working environmental climate of the Center, including the following: (1) participative management, (2) inservice training based on staff needs assessment, (3) weekly staff group process to deal with interpersonal conflict, (4) annual evaluation, (5) responsibilities of the supervisors, (6) communication patterns, and (7) support systems. Results of an exploratory survey of staff perceptions of the social climate are also presented, with an overall indication that staff are overwhelmingly positive in their general ratings of satisfaction. (Author/HLM)

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Evolution of a Humanistic Work Environment for Mental Health Professionals[1]

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Abstract

Both a quantitative and qualitative description and analysis of a community mental health center are offered. The center is described in an historical, evolutionary and current context. Following this, a quantitative analysis is described which tends to confirm many of the points made in the qualitative analysis. The center is seen as providing a humanistic environment which is conducive for both service to clients and employee and agency growth.

Evolution of a Humanistic Work Environment for Mental Health Professionals

Introduction

A common problem in mental health facilities is staff dissatisfaction with the work environment. This takes the form of burnout, apathy, and ultimately resignation, resulting in high staff turnover. Common complaints include high caseloads, bureaucratic expectations and demands for what staff consider to be irrelevant and time consuming paper work, evaluation anxiety, staff gossip, and general fatigue due to the emotional strains in the work environment. This presentation describes a currently functioning work environment which the participants feel comes close to being an ideal work setting for mental health professionals. This is so in spite of the reality demands which this center shares with other centers of its kind--paper work, statistics, progress notes. The hope is that this environment can be a model for other outpatient mental health facilities.

The plan is to trace the history and evolutionary development of the center, with particular emphasis on describing administrative interventions designed to both (1) alleviate excessive stress and strain in the system, and (2) provide for growth experiences that prevent stagnation among the staff.

(It is our belief that these process goals ultimately serve to enhance obtaining an outcome goal of assuring that high quality mental health, alcoholism, and drug abuse services are provided.) A theme central to these interventions has been allowing staff to vent their feelings and to have significant input into decision making (although ultimate authority rests with senior administrative staff). Staff have been involved in committee work and the attendant processes which occur in such committees. In addition, a number of process groups have allowed open channels of communication in all directions. Another important theme has been the furtherance of growth of each individual staff member. Even with a rather limited budget, staff have been able to attend a variety of inservice meetings both at the center and in other locations. It is important to note that these functions have occurred with no corresponding waiting list of clients.

The focus of the administrative intervention has been on the maintenance of a moderate amount of anxiety within the system in order to facilitate growth of individuals and consequently to upgrade the center's capabilities. The theoretical approach in the presentation will be to describe staff members as fitting into a family-type unit, with the attendant forces impinging upon the family-type system.

Following the executive director's description of the historical and evolutionary developments at the center (currently in its seventh year), the clinical director will describe the system as it currently exists. The Director of the Outpatient Program will then describe the structure and dynamics of the outpatient program as a representative sample program at the center. This qualitative analysis will be followed by a quantitative analysis. Data obtained by polling staff with regard to their views of the system will be presented. Parenthetically, it should be noted that the philosophies expressed herein are those of the authors alone, and may not necessarily be official agency policy. Of course, we also recognize that our staff may disagree with some of our points and interpretations.

Executive Director: Historical and Evolutionary Developments At This Center

Historically, the Tazwood Center for Human Services began a little over seven years ago as a satellite of a large parent clinic situated in an adjoining county. Unlike the large parent clinic which served a densely pop-

ulated, urban area, the satellite would serve a predominately rural, two-county catchment area.

The months preceding the "opening of doors for business" were busily occupied in educating civic leaders and governmental bodies in the identification of mental health problems and contacting professional caregivers in the area to garner their input as to the need for mental health care. An advisory committee was recruited and negotiations were successfully concluded to acquire the loan of clinicians from mental health facilities in the area.

During our infancy, professional mental health services were provided by four clinicians: myself in the dual role of administrator/clinician, two psychologists and one social worker. One additional person was also utilized in a support role.

My professional experience in the private practice sector, institutional settings, and in the community mental health center nourished my belief that there should be an alternative to the traditionally authoritative form of administration.

From this deeply imbedded belief came my decision to move in the direction of a team approach. Weekly staff meetings were initiated and all levels of staff were encouraged to participate and voice their input.

With the days of infancy behind us, we began to experience growing pains that could be likened to those endured by any child. Responding to a plea from community leaders of the other county in our service area, a full-time clinic was opened in that area. By this time, our professional staff had grown and included: myself as Executive Director, a .PhD psychologist as Director of Clinical Services, a psychiatrist working part-time in each of our centers as opposed to being situated in the parent clinic some miles away, four psychotherapists, and two support staff. The clinical staff split their time between the two centers as they chose; that is, considering the caseload at each center, they undertook the responsibility of assigning themselves the appropriate number of hours at each location to handle the caseload. Caseload in this instance is defined as both direct service to the client and services that are provided in the community.

Within three years of its inception, it was obvious that the satellite had matured sufficiently and was straining to advance to its next stage of life. With the blessings of the parent clinic, all ties were severed and we were at last an autonomous, duly incorporated mental health center complete with our own budget and Board of Directors.

As new growth continued to occur and our staff became more widely dispersed over two counties, the family feeling we had enjoyed was showing signs of stress. I was convinced that the successful growth we had experienced and were continuing to experience, along with the professional recognition we had attained in the community, was closely tied to this feeling of being a family. The caring attitude that the staff had for one another carried over into the services being given to the clients.

The preservation of this atmosphere was utmost in my mind as Executive Director. I began to guide all center services into four basic programs: 1) outpatient mental health, 2) alcohol outpatient, 3) sustaining care, and 4) drug counseling. The next step was to adopt a new job category aptly designated "Program Director." This is

probably the most dramatic change in administrative policy that has occurred within our agency in that for the first time, administrative authority would be delegated to someone other than the Executive Director. The personnel of each program contituted a team -- the Program Director became the team leader.

This same structure sets the tone of administration for the Tazwood Center today. The administrative team consists of: Executive Director, Clinical Director, Outpatient Program Director, Sustaining Care Program Director, Alcohol Program Director, Drug Program Director, and Office Manager/Executive Secretary. This team gives all employees an avenue of input to administration. Each Program Director works with the staff of their program through this same concept so that all matters are handled through the team approach. A sample of administrative matters that may be discussed at the program team level are: 1) allocation of program funds; 2) selection of employee insurance plan; 3) what space needs should be attended to in new agency location. A sample of individual program matters are: 1) peer review;

2) possible additions to present program services; 3) training needs; 4) supervision needs of new employees. Also, we presently hold one meeting on the first Friday of each month for our entire staff including all support people.

Clinical Director: The Current System

In this section I will attempt to describe the system as it currently exists. First, I present a summary of the services we provide; this is followed by a description of our clinical leadership and program philosophies. Then I touch upon the social climate of the center from management's perspective and include such concepts as participative management and staff conflict. Staff evaluation and staff supervision are also considered.

Current Services

Today Tazwood Center provides outpatient mental health, drug abuse and alcoholism services to Tazewell and Woodford Counties in central Illinois. These counties are located midway between Chicago and St. Louis. This area is seen as an economic pocket of prosperity and is rich in both farmland and industry. Tazewell County has a popula-

tion of approximately 124,000 and is primarily an urban area. Woodford County, a rural setting, has 29,400 people. Tazwood Center operates three offices serving Tazewell County and one serving the relatively small Woodford County. Approximately 3000 persons are served yearly.

Services are provided by a staff of 34 clinical and 9 clerical personnel. An outline of clinical services, as we present them to our clients, follows:

- Individual Psychotherapy: A counselor trained in psychotherapy sees the client once a week to help him or her better understand and cope with life adjustment problems and to change problem patterns of behavior.

- Group Psychotherapy: Clients may participate in a group when this sort of therapy is advisable. The therapist helps the members of the group explore their feelings and behavior with the goal of increasing their self-awareness and ability to better relate with others.

- Psychopharmacological Therapy: Medical consultation is provided to those individuals for whom medication is a beneficial adjunct to their treatment.

- Community Placement: Consultation and direct services are provided for those persons with a history of psychiatric problems who are residing in shelter care and nursing homes.

- Marital Counseling: A marriage counselor sees the husband and wife for individual and joint interviews to help them clarify and resolve their marital problems. Premarital and divorce counseling are also provided.

- Family Therapy: A family counselor will see all members of a family where difficulties affect the family as a whole. This may involve sessions where parents and children are seen together.

- Alcohol Abuse: The Alcohol treatment program consists of group and individual therapy, plus marital and family therapy on an outpatient basis where alcohol related problems exist. Alcohol education and prevention programs are made available to clubs, schools and other civic groups.

- Driving While Intoxicated School: The DWI School (Driving While Intoxicated) is an educational experience regarding driving and drinking for those people who have received a DWI arrest. It operates in coordination with the State's Attorney Office.

- Drug Abuse: Counseling services are provided to youth and their families involved with drug related problems and other adolescent adjustment difficulties; outreach services are provided to schools and other agencies.

- Day Treatment: This is a psychological rehabilitation program with components of individual therapy, group therapy, recreational and activity therapy. Persons attend this program from one to five days per week, and go home at night. It is an alternative to inpatient hospitalization.

- Post Hospitalization: Follow-up continued treatment for individuals who have completed an inpatient treatment program. This includes individual or group therapy in conjuntion with medication evaluation and monitoring.

- Emergency Services: A mental health worker is available to help in crisis situations 24 hours a day, seven days a week.

- Consulting Services: Consulting services are provided for social agencies and other community caregivers.

- Many Seniors Way: This is a transportation service for the senior citizens of Woodford County. The purpose of this service is to provide transportation for doctors' appointments, shopping, social events, etc., to elderly people who otherwise would have no transportation.

- Drug Attitude Reassessment Seminar: This is an educational experience about drug abuse for persons who have received a drug related arrest.

- Child Abuse Treatment: In this program family counseling methods and education are applied to treat and prevent family violence.

- Employee Assistance: This service provides help to employees and employers in local industries when alcohol abuse or other personal problems interfere with an employee's job performance. Consultation and supervisor training are provided to employers; the full range of our Center's services is available to employees.

Center Leadership

Day to day clinical operations at the Center fall under the leadership of the administrative staff, consisting of an Executive Director, Clinical Director and four Program Directors. The Executive Director is responsible to the Board of Directors; he is responsible for centerwide administrative matters such as grants, budgets, etc. The Clinical Director is responsible for such clinical matters as evaluation, quality of care and training. Each program

director directs one of four clinical programs, around which the Center is organized. A philosophical description of each clinical program follows. (The above mentioned clinical services may be provided by one or more of the following clinical programs.)

Program Philosophies

Alcoholism Program. Alcoholism is a progressive debilitating condition involving various degrees of the uncontrolled use of alcohol, which is accompanied by on-going problems with life-adjustment in the areas of family, job, money, reputation, health and psychic stress. Alcoholism may or may not include physiological addiction or habituation.

The following guidelines provide the foundation for the alcoholism treatment program:

1. Because alcoholism is a progressive disease, the problem drinker's illness and difficulty can only intensify with time.
2. If the family will accept the responsibility to follow a planned educational and counseling program, there is every evidence that the problem drinker can be helped.
3. Far from having any positive value, passively accepting or ignoring the problem gives the alcoholic little hope for recovery.
4. Alcoholism is a treatable disease.

As its treatment model, the alcoholism program utilizes the family counseling approach that an aggressive and family-oriented policy can oftentimes anticipate and arrest the alcoholic's progressive illness. A model for prevention includes consultation and education services.

Sustaining Care Program. The Sustaining Care (Post-Hospitalization) Program is considered to be a crucial element in reducing the recurrence of psychiatric hospitalization among community members. Treatment may focus upon the individual patient, but often involves the entire family in the healing process. Counseling and psychotherapy provide the framework for treatment.

The Sustaining Care Program helps to assure the most satisfactory adjustment of a person's return to his or her community, family and job following a period of hospitalization. Special attention is given to the emotional and psychological needs of the post-hospitalized patient and his or her family with emphasis on continuation of treatment that may have been initiated at the hospital.

Medication may be prescribed as an adjunct to psychotherapy and social learning therapy.

Outpatient Program. The Outpatient Program philosophy offers a flexible approach to psychotherapy, depending upon (a) client needs and (b) therapist strengths and interests. While the majority of our clients benefit significantly from a form of brief, active psychotherapy, there are others who need to do additional exploration of themselves and who need to stay in treatment longer. Therapists tend to be eclectic in approach; most are at least familiar with the multiplicity of common approaches (Gestalt, RET; Psychoanalytically-oriented psychotherapy; Rogerian; Behavior Modification). Therapists tend to integrate these "approaches" into their own philosophies of what therapy means. Therapists have freedom to explore a variety of therapeutic approaches and to "experiment" within bounds of sound practice.

Drug Counseling. This program is a drug abuse service aimed primarily at youthful drug abusers. Its philosophy is that youthful drug abuse is a family problem, and so whenever possible a family treatment approach is undertaken.

The Social Climate

Given the existence of the four clinical programs described above, with from 3 to 11 staff persons assigned to each program, some kind of organizational atmosphere must emerge. Such an atmosphere, as we see it, may range from highly bureaucratic to highly humanistic, depending on the managerial style of the administrative staff. A highly bureaucratic atmosphere can be described as one laden with constraints that lead to staff burnout, apathy, resignation, dissatisfaction and high turnover. A center governed by a tightly structured network of rules and regulations that delimit staff autonomy, decrease the staff's sense of importance and increase interpersonal distance among staff is illustrative of such an atmosphere. In contrast, a highly humanistic atmosphere is one that fosters the continued growth and development of the staff in spite of the reality demands that impinge upon them -- paper work, statistics, difficult cases. The administrative staff has made a variety of decisions which, we feel, has fostered the development of a humanistic work environment for mental health professionals.

The decision to establish four clinical programs was made two years ago during a time of considerable growth and

expansion. Because funds were then readily available, additional services were developed and staff hired. In short time, the Center grew from a small organization of 15 to a moderately sized one of close to 40 employees. Each clinical program was developed as an autonomous, reasonably decentralized unit, with an identity of its own. For staff, this helped to maintain a sense of smallness in a rapidly growing organization.

Participative Management

The managerial style of the Center, from its inception, has been participative management. Creative brainstorm sessions and other forms of input from staff at all levels, regarding management and clinical problems, are not unusual. There is a structure for this at the monthly meeting (attended by clinical, clerical and administrative personnel). New directions in clinical programming and in-service training, staff burnout, and changes in the pay scale are some of the topics that have been discussed. Small group discussion, with feedback to the larger group and administrative staff, has proved to be a workable format. Some very constructive ideas have emerged.

The development of the current in-service training programs is a case in point. Small group discussions helped to identify staff training needs, as well as the kinds of programs staff felt they would have the most interest to attend. As a result, the following six time-limited training programs are currently being offered being offered to staff: 1) Alcoholism in the Family 2) New Developments in Body Techniques in Psychotherapy, 3) Cardiopulmonary Resuscitation, 4) Case Review and Presentation, 5) Creative Ways of Dealing with the Family, and 6) Group Therapy Training Group. Senior staff members and outside consultants provide these programs. Most programs are offered once per week over a 15-week period.

Participative management is a democratic leadership style in which staff ideas and opinions are solicited before final decisions are made. A major advantage of this is that, in general, the more involved the staff is in the decision-making process, the more staff cooperation and support can be expected. For instance, after involving staff personally in the development of in-service programming, staff attendance at such programs increased considerably. Of course, participative management is not the only leadership style, nor is it the only style we use. Nor is it always preferred by all staff all the time.

Participative management, when used exclusively, can be too anxiety provoking, the result of which is often staff ambiguity and confusion. Staff do need to know that someone is in charge, and participative management is no substitute for weak or indecisive leadership. I found this to be particularly so as the size of the staff increased, and staff began asking the administration for clarity on various policies, procedures or issues. They did not want to be involved in the policy-making sessions; they merely wanted structure.

Interpersonal Conflict and Group Process

No human environment is conflict-free, and this environment is no exception. Conflict and interpersonal difficulties among staff and between staff and supervisors are apt to occur. We decided early on to accept this notion as inevitable along with the idea that if staff had a setting in which they could work through their differences, and were encouraged to do so in a supportive and constructive way, the quality of patient care would ultimately be enhanced. Therefore, a weekly staff group process was established almost concurrently with the opening of the Center in 1972 and lasted until 1979.

The overall purpose of the group process was to provide for professional and personal growth experiences that prevent stagnation and burnout among staff. Led by an expert, outside process consultant, the group was primarily concerned with the following areas of growth: 1) intrapersonal and, as indicated above, interpersonal problem resolution; 2) understanding psychodynamics; and 3) providing staff with an armamentarium of therapy skills and techniques. While the focus of the group centered around these areas, the specific issues and problems dealt with through the years varied widely, according to the needs of participating staff members.

Staff attendance was not mandated; participation was voluntary. During the first few years all clinical staff attended, as well as the executive and clinical directors. As the Center grew in staff size and the four clinical programs were established, however, the need for the group process seemed to decrease and attendance dropped off. Apparently, this was not because the functions provided by this group were no longer needed but because those functions were now being handled in program meetings, with either the clinical director or program director serving as process leader.

Annual Evaluation

All employees are given a performance appraisal annually and, if the evaluation is favorable, are eligible for a salary increase.

The purpose of the evaluation is to aid the agency and the individual. The agency needs to have competent people working for it, and the individual needs to upgrade his/her skills so as to advance in the profession. Annual evaluations are performed not with the purpose of criticizing or putting down but with the purpose of encouraging, motivating and facilitating. My experience has been that evaluations are often seen as scary and of little value to the employee. One of the major thrusts of the evaluation here is to process the feelings surrounding the evaluation, and to deal with any conflicts which ensue between supervisors and supervisorees.

Staff Supervision

It is a difficult and complex task to list the qualities and qualifications of a good mental health supervisor. Obviously, experience is one important

factor, and so our experienced staff supervise beginners. With good supervision and with guidance from one's program director and the clinical director, a staff member may become a supervisor in about three years. Some staff may do supervision with the permission or aid of the program director as a temporary assignment, as for example, in preparation for a grade promotion.

The length of time one remains in supervision depends on one's skill level and progress. Supervision is not intended to be a never ending process; rather the goal is to help the supervisee become an independent therapist using consultation, continued education and in-service training as the means of gaining increased knowledge and skills.

Outpatient Program Director: The Outpatient Program

I have been Director of the Outpatient Program for a little over fifteen months. Prior to that I was a staff psychologist at a university counseling center. In this section I would like to describe the structure and dynamics of the outpatient program as a representative program at the center.

Program Structure

The primary purpose of the outpatient program is to provide psychotherapy to all community clients who do not fall into other specific categories (i.e. those with specific alcohol or drug related problems, and those who have been recently institutionalized). (This makes up a large portion of clients seen at the center) The majority of our clients are not psychotic, and most function independently in the community.

Staff is composed of five full time and one half time masters level psychotherapists, with degrees in either psychology or social work. There is one doctoral level registered psychologist (myself) who spends approximately 50% time in direct service and 50% in administrative work. There are three part time masters level staff with specialized functions. (One runs a boys group two hours a week, one sees children in therapy four hours per week, and one sees outpatiens four hours per week.) In addition, there is one full-time child abuse worker who works primarily in a field setting.

The bulk of staff time is devoted to direct service with clients in individual, group, marital and family therapy and counseling. Advanced staff are involved in supervision of beginning staff. Approximately 10% of the

week is devoted to in-service training of various types, both didactic and experiential. Staff are also involved in a number of committees, in which they have input into administrative policy (We have had an "Inservice Programs" committee, and a supervisory committee thus far). The Outpatient staff as a whole meets once a week for a business meeting. During this meeting, I will relay relevant information from our Program Directors' meeting, ask for outpatient staff feedback, and plan future programs. Currently, the thinking is to keep this meeting a business meeting, and not deal formally with clinical issues. (This has not always been the case; the structure frequently changes to provide for current needs). The outpatient meeting has also, in the past, served as a setting for clinical peer review, and for a variety of clinical workshops within the agency in which outpatient staff participate.

A number of staff are involved in leading some of the current inservice offerings. I run a didactic-experiential group made up of therapists wishing to improve their group therapy skills. One of the more experienced therapists runs a bioenergetics group. Another staff

member has been involved in the planning board of the local mental health forum which provides an annual series of talks on mental health for the community.

Communication Patterns

The model of communication is family-oriented. This means that staff members expect all the privileges and are willing to face up to all the responsibilities involved in a well-functioning family. When someone isn't doing their job, for example, this tends to get noticed by a variety of people, and the staff member neglecting the responsibility is informed. On the other hand, if someone feels he or she is missing out on some privilege which other staff are receiving (money for inservice attendance, travel reimbursement, etc. etc.), he or she will usually raise the issue loud and clear.

As in any well-functioning family there are disagreements and conflicts. In outpatient staff, these kinds of conflicts get taken care of in a number of possible ways:

(1) the two or more individuals involved resolve the problem directly.

(2) a "mediator" is asked to facilitate resolution of the problem between the individuals involved.

(3) the problem does not get dealt with.

I strongly encourage (1) or (2) to occur if this is at all possible. When staff members can resolve problems communication lines remain open. This benefits the individuals involved as well as the program. It also encourages continued interaction and growth in the network of activities in which staff members participate. This, in turn, generates new and orginal staff programs, serving new clientele.

One recent conflict resolution involved a fairly experienced older staff member and a relatively new staff member. The new staff member had actually felt a variety of fears and conflicts toward the older staff person for almost a year, but neglected to express his feelings. The trouble had developed during a staff growth group in which a number of comments made by the older staff member had been mistakenly taken by the new staff member as criticism of the new member. A 90 minute session, in which I helped clarify and facilitate, resulted in new understanding between the two therapists. They are currently involved in Co-therapy, running a couples' communication group. Although I strongly encourage such communication (although it is painful) to occur,

I realize that not everyone will love everyone else, and that conflicts and differences of opinion will continue to occur between people. Some of these may be deep and unresolveable. Ultimately it is left up to the individuals involved to resolve or not resolve their differences.

Although staff must spend a good deal of time on paper work (statistics to be reported to the state, progress notes, intake notes, reports to be sent out), the bureaucratic aspect of the job is down played. These things must be done, and these things are expected of people. Fulfilling responsibilities such as statistics are seen as necessary to the survival of the center's funding and functioning. Staff understand this as a necessary evil, without which there would be no funding.

Support of each other is strongly encouraged. A mutual support network existed long before I began working at the center. Quite honestly, I found that there was so much support that some staff were often unable to be constructively critical about their work. One example of this occurred in outpatient meetings. We have been involved in peer review in these meetings. I quickly found that one of the problems here was that staff tended to give unrealistically positive feedback to each other, presumably because of the fear of reprisal if negative (albeit constructive) feedback

were given. I have tried to teach this skill of giving constructive criticism in the groups in which I have been involved. Giving constructive criticism means taking risks, saying things which the person does not like or even want to hear; it represents a productive channeling of one's anxiety. Without the underlying base of support, of course, criticism (whether constructive or destructive) tends not to get heard, and is therefore totally unbeneficial to the individual.

Structually, communication is open in all directions. As in a healthy family there is no required pattern that one must follow all the time. Staff are encouraged to communicate with peers, supervisors and superiors. Although "channels" exist they need not be rigidly adhered to.

Administrative staff believe that although their authority must be respected, the press is not strong in this direction; rather, an atmosphere of open and honest communication is vital for adequate functioning in a very demanding environment. Therefore, questions are always encouraged, and staff input is seen as extremely important.

Co-Therapy

One type of growth which is highly encouraged occurs in Co-Therapy. Staff are strongly encouraged to work with peers with whom they have not worked previously. This is seen as helping the therapist to learn (a) how to work cooperatively in a therapeutic atmosphere; (b) how to work through conflicts (with co-therapists) in a constructive manner; (c) what one's own style of therapy is, and how it differs from the style of one's co-therapist. Conflict is seen as inviteable and necessary, and, in fact, as a factor which minimizes burnout.

Limit Setting

I have found that the outpatient staff are hard workers and, if anything, need to relax and have limits set on them from time to time. The limits I speak of pertain to a variety of areas:

(1) Limits on the number of patients they are willing to accept.

(2) Limits on the number of hours they work at the Center; employees frequently wind up working more than is required.

(3) Limits on the number of requisitions employees make. For example, staff would like improvements in the building, one way mirrors, etc., immediately. Although administrative staff is

seeking to upgrade facilities, this must be done within realistic budgetary constraints.

(4) Limits on salaries. This is perhaps the the issue which upsets the most staff most often, as staff often feel they work harder than their salary would indicate.

As can be seen, I find myself in a position of having to set limits on both (1) staff responsibilities and (2) staff privileges.

Ultimately, some staff energy must be directed away from the center and towards other pursuits, so that burnout and staff turnovers are minimized.

Limits and Privileges

Staff must be dealt with fairly. It is important to have a consistent agency policy, so that staff perceive a just administration. If sabbaticals are open to one staff member, they should be open to all staff. (Or a reason must be given as to why one individual received preference.) If one individual is spending time in the less attractive satellite office of the center, that person will expect others to put their time in as well. (Or at least negotiate as to why they will not be doing so.) Thus, the limits and privileges are applied in a fair, consistent manner, and are discussed publicly at outpatient meetings.

The Ripple Effect

Another interesting ramification of this system is "the ripple effect" Changes (sometimes very slight) in one part of the system (or program or agency) affect changes in other parts. Two brief examples will help clarify this point. (1) The agency recently moved its main office to a more spacious, newly decorated area in an attractive downtown bank building. Prior to this, many staff had tended to spend more time in the satellite offices. Several months prior to the opening of the bank building area these staff began to request more time in the main office - an obvious attempt to "get in line" for office space and privileges in the new bank building. This needed to be dealt with in a fair and equitable way. (2) Recently a staff member asked for educational leave to pursue work towards an advanced degree. It quickly became clear that other staff wanted similar privileges, and that some consistent policy needed to be framed encompassing points such as (a) who could qualify for such leave, (b) what benefits would be allowed during such leave, (c) what responsibilities the staff person would have when returning. The agency did in fact establish a policy of "sabbatical leaves"

The Future

My hope is that our staff increases in the future. With expanding community education, the need for mental health outpatient services should be more keenly felt. However, I am hoping that our family-type system remains. I feel this can be done regardless of size; what is needed is a management attitude that staff are most productive and satisfied when they have significant and perceived control over their work environment.

QUANTITATIVE ANALYSIS

The purpose of this part of the analysis was to provide an exploratory survey of staff perceptions of the social climate in which they are employed.

Method. The subject pool consisted of all full-time treatment personnel, the administrative staff and the clerical staff (N=43). Participation was voluntary; all agreed to participate. There were 28 females and 15 males; their mean number of years of experience in mental health work was 4.09 (S.D.=3.70; range=0-7); forty-five percent of the treatment personnel held a graduate degree.

Instruments. During regular program meetings staff were asked to anonymously complete two forms: the Work Environment Scale (Moos, Insel and Humphrey, 1974) and a brief background information sheet.

The Work Environment Scale is a 90-item true-false instrument that measures the perceived social climate of the work setting. It yields 10 subscale scores which measure and describe three environmental domains: An Interpersonal Relationship domain is reflected by Involvement, Peer Cohesion and Staff Support; a Personal Growth domain is reflected by Autonomy and Task Orientation; and Organizational Structure is reflected by Work Pressure, Clarity, Control, Innovation and Physical Comfort.

The background information sheet yielded staff demographic information and included a global question referring to job satisfaction. Staff were asked to rate their level of overall satisfaction with their employment at the Center on a six-point Likert type scale. The scale points were (1) Extremely Satisfying; (2) Very Satisfying; (3) Satisfying; (4) Dissatisfying; (5) Very Dissatisfying; (6) Extremely Dissatisfying. Staff were in-

structed to make the rating after reflecting on the following factors: Administrative leadership; clinical supervision; case load; interactions with supervisors, peers and clients; statistical chores; and other paper work.

Results

The mean score and standard deviation of staff satisfaction with employment were 2.74 and .74, respectively. The range of responses was from (1) Extremely Satisfied to (4) Dissatisfying.

Table 1 compares the mean scores of our local sample with the national norms on each of the ten variables on the Work Environment Scale. The national norms were established by Moos et al. (1974) on 624 workers representing 44 diverse work groups. A series of t-tests indicated significant differences between our sample and the national norms on seven of the ten variables. Staff at our center indicated greater involvement, autonomy, and work pressure existed compared to the national sample. They indicated that less task orientation, clarity, control, and physical comfort existed at our center, compared to the national sample responses. Thus, overall, in

terms of Moos' et al. (1974) environmental domains (See Method section), our staff perceives slightly greater emphasis on interpersonal relationships and personal growth and considerably less emphasis on organizational structure.

Insert Table 1 about here

In an attempt to determine the possibilities of predicting job satisfaction at the center, we performed a multiple regression of satisfaction scores with all other variables. The results are presented in Table 2. As can be seen, the variable accounting for the most variance was Physical Comfort. This variable accounted for over 24 percent of the variance and yielded a highly significant F score (F=13.04, $p < .001$). The second most significant variable from among our population of variables in predicting satisfaction scores was peer cohesion. This variable accounted for an additional 14.7% of the variance (F=9.58, $p < .004$). The remaining 15 variables (not shown) accounted for a total of 8.8% of the variance in predicting satisfaction scores, but none of them individually

accounted for greater than 4.4% of the variance, and none yielded significant F scores.

Insert Table 2 about here

We also investigated the effects of education, salary, and the professional-clerical dichotomy on our dependent variables - each of the ten Work Environment Scale scores and satisfaction. These calculations are presented in Tables 3, 4, and 5. For each independent variable, a Hotelling's T-test was performed.

Insert Table 3 and 4 about here

As can be seen in Table 3, there were no overall effects of education on the dependent variables (T^2=23.8; F=1.62; df=11, 30; SIG=.142). On an overall basis, individuals with advanced degrees did not respond differently than individuals with a Bachelor's Degree or below. When staff were dichotomized by professional vs. clerical categories (Table 4) a significant overall difference was obtained (T^2=35.92; F=2.47; df=11, 31; SIG=.024). The individual univariate t-tests indicated professional

staff said there was significantly less clarity to the job than did clerical staff (t=2.92; p<.006). In addition, professional staff said there was significantly less physical comfort to the job than did clerical staff (t=2.17; p<.036). In terms of Moos' et al. (1974) environmental domains (See Method section) these differences between the professional and clerical staffs occured only in the domain of organizational structure rather than in the areas of interpersonal relationships or personal growth. When staff were divided by salary into groups above and below the median salary (Table 5), a significant overall difference on the dependent variables was again obtained (T^2=37.32; F=2.57; df=11, 31; SIG=.019). Individual univariate t-tests revealed a significant difference on four dependent variables: one in each of the environmental domains and one in the area of job satisfaction. Hence, higher paid staff indicated there was more staff support (t=2.84; p<.007), more autonomy (t=2.04; p<.048), less control (t=2.84; p<.007), and more satisfaction (t = 2.05; p < .047) to their job than lower paid staff.

Insert Table 5 and 6 about here

Finally, a correlation matrix is presented in Table 6. In this table, a correlation of at least .26 is required for a $p < .05$ significance level to hold. A number of points come to light:

(1) Both number of years in mental health and number of years spent at Tazwood Center correlate significantly with six of the ten Work Environment Scale variables. These were all the interpersonal relationship subscales as well as one personal growth subscale and two organizational subscales. Thus more experienced therapists indicate more involvement, peer cohesion, staff support, autonomy, and innovation, and perceive less control in their environment. They make a higher salary and are more satisfied with their work.

(2) Education level correlates with five of the ten work environment scale variables. Like years of experience, education seems to be related to all three environmental domains. But the domain most affected by education is that of organizational structure, with three of these five subscales showing significant correlations with education. Staff with higher education indicate more involvement, autonomy, and work pressure, and less clarity

and control than those with less education. As would be expected, education level correlates with salary as well.

(3) Salary correlates with four of the scales. Staff receiving higher salary indicate more peer cohesion, staff support, and autonomy than lower paid staff, and perceive less control in their environment. Higher paid staff indicate higher satisfaction with the job than lower paid staff.

(4) Satisfaction correlates with the three relationship scales (Involvement, Peer Cohesion, and Staff Support), and also correlates highly with Physical Comfort.

(5) Neither program nor sex of staff correlates with any of the dependent variables.

Discussion

The quantitative analysis was undertaken for the purpose of better understanding staff feelings about their work environment. This was an exploratory survey and a variety of analyses seemed warranted. Of great interest is the fact that staff were overwhelmingly positive in their general ratings of satisfaction: The mean score was halfway between "very satisfied" and "satisfied," with one response of "dissatisfied" and no responses of "very dissatisfied"

or "extremely dissatisfied." These findings run directly counter to other published literature (Cherniss and Egnatios, 1978) which suggests that community mental health work is unusally frustrating and dissatisfying for staff.

We were generally not surprised with the staff's Work Environment Scale scores compared with national norms. In a job requiring intense concentration and emotional sharing, it is understandable that staff would express a great degree of involvement, and feel a significant amount of work pressure. We expected antonomy to be high, and task orientation, clarity and control to be low because of the administrative philosophy described in our qualitative section. We were somewhat surprised that peer cohesion and staff support did not differ significantly from the national norm. We had expected these variables to be significantly higher in our sample. However, a finer analysis revealed a wide range of responses by program (at least in the case of peer cohesion). (We will not be concerned with these differences in this paper.) Finally, it was understandable that physical comfort was low for many staff, as space for a number of staff was tight and uncomfortable, prior to the center's pending move to newer, larger quarters (scheduled for August, 1979).

A more powerful confirmation of the humanistic nature of the center could be evidenced had we used a control group consisting of one or more other mental health centers. The available data merely allows us to compare our center with workers in general.

Surprisingly, physical comfort accounted for the largest proportion of variance in determing satisfaction responses. We believe that the fact that physical comfort carried the highest beta weight is in part an artifact of the physical set-up of our center as of June, 1979, when the data for these analyses were collected. Some programs were housed in more desirable quarters than others. It would then stand to reason that this variable would carry a wide range of responses and would thus be a good predictor variable in the satisfaction regression equation.

We feel that peer cohesion, the variable accounting for the second largest proportion of variance in the equation, probably carries more generalizability to other mental health settings. That is, it is likely that the amount of cohesion experienced by a staff member will be an important factor in determining satisfaction with the mental health job setting. Peer cohesion measures the degree to which staff members are friendly and supportive

of one another. High peer cohesion is reflected when staff answer true to items like: "People go out of their way to help a new employee feel comfortable," "People take a personal interest in each other," and "Employees often eat lunch together." Interestingly enough, none of the other variables added a significant amount of variance to the regression equation to be considered worthwhile studying.

The amount of education an individual had did not effect responses on dependent variables. However, whether a staff member was a professional or clerical did appear to affect responses. Professional staff indicated less clarity and less physical comfort than clerical staff. The difference in clarity follows from the different role definitions in the two types of jobs. The difference in physical comfort is less clear, as clerical staff worked in all areas of the center. It is possible that the therapy role behaviors interacted with the physcial setting and made the therapist respond more acutely (negatively) to the questions relating to physical comfort.

Higher paid staff appeared to feel more "in control" of their environment than lower paid staff. They felt

greater staff support, more autonomy, less controlled by external sources, and more satisfaction. It is likely that other related variables such as experience and responsibility (a variable we did not measure) contribute to these differences as well.

The correlation matrix provides an interesting base for discussion. The more experienced staff tend to score higher especially in the relationship dimensions. These dimensions are seen as crucial at the Center, because of the nature of our business. Experience is also related to increasing autonomy, and more internalized control.

Increased education is not so much related to relationship dimensions as it is to autonomy, work pressure, and increasing ambiguity (less clarity). Interestingly, satisfaction correlates significantly only with the relationship dimensions (Involvement, Peer Cohesion, and Staff Support) and Physical Comfort. An employee's overall rating of satisfaction is primarily related to his or her perception of the social context of the job, as well as his or her physical comfort on the job. This has suggestive implications for structuring the work environment to increase employee satisfaction.

There were no significant correlations between sex of staff and the dependent variables, or between the program in which an individual worked and the dependent variables. Apparently, one's level of education, salary, and level of experience were far more related to one's reponses.

References

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TABLE 1

Mean Scores, WES, Local and National Sample

Variable Categories	Local Sample(N=43)		National Norms(N=624)		t	p
	Mean	S.D.	Mean	S.D.		
Involvement	7.12	1.53	6.64	1.39	-2.16	.03
Peer Cohesion	6.37	2.32	5.84	1.00	-1.49	ns
Staff Support	6.30	2.51	6.00	1.20	-.78	ns
Autonomy	7.05	2.02	5.62	1.09	-4.58	.00005
Task Orientation	5.21	1.94	6.44	1.19	4.09	.0002
Work Pressure	5.14	2.37	4.37	1.65	-2.10	.05
Clarity	3.77	2.10	5.78	1.32	6.19	.00005
Control	3.37	2.28	5.05	1.65	4.74	.00005
Innovation	5.37	2.74	5.08	1.84	-.68	ns
Physical Comfort	2.74	2.04	5.64	1.69	10.71	.00005

TABLE 2

Stepwise Multiple Regression of Satisfaction with Variables Yielding Significant F Values

Step	Variable Entered	F	Significance	Multiple R	R^2	Simple R
1	Physical Comfort	13.04	.001	.491	.241	.49
2	Peer Cohesion	9.58	.004	.023	.388	.45

TABLE 3

Effects of Education[a] On Dependent Variables

Dependent Variable		Mean	S.D.	Pooled Variance Est. t	Pooled Variance Est. 2-Tail Prob.
Involvement	Group 1	6.89	1.48	-1.84	.074
	2	7.73	1.33		
Peer Cohesion	1	6.04	2.23	-1.28	.207
	2	7.00	2.51		
Staff Support	1	5.96	2.79	-1.28	.208
	2	7.00	1.89		
Autonomy	1	6.59	2.26	-2.00	.052
	2	7.87	1.30		
Task Orientation	1	4.85	2.14	-1.52	.136
	2	5.80	1.47		
Work Pressure	1	4.93	2.37	-1.07	.290
	2	5.73	2.28		
Clarity	1	3.96	2.24	.82	.418
	2	3.40	1.92		
Control	1	4.04	2.44	2.77	.009
	2	2.13	1.41		
Innovation	1	5.04	2.93	-.93	.358
	2	5.87	2.45		
Physical Comfort	1	2.74	1.87	.21	.833
	2	2.60	2.35		
Satisfaction	1	2.59	.75	1.69	.100
	2	2.20	.68		

T^2=23.8 F=1.62 df=11, 30 SIG=.142

[a]Group 1=B.A.Degree or below (N=27) Group 2 = M.A. Degree or above (N=15)

TABLE 4

Effects of Type of Staff[b] on Dependent Variables

Dependent Variable		Mean	S.D.	T	Pooled Variance Est. 2-Tail Prob.
Involvement	Group 1	7.24	1.54	.99	.328
	2	6.67	1.50		
Peer Cohesion	1	6.29	2.43	-.42	.674
	2	6.67	1.94		
Staff Support	1	6.06	2.50	-1.24	.221
	2	7.22	2.49		
Autonomy	1	7.09	2.12	.26	.796
	2	6.89	1.69		
Task Orientation	1	5.18	1.99	-.21	.833
	2	5.33	1.87		
Work Pressure	1	5.41	2.27	1.49	.145
	2	4.11	2.57		
Clarity	1	3.32	1.89	-2.92	.006
	2	5.44	2.13		
Control	1	3.09	2.22	-1.62	.113
	2	4.44	2.30		
Innovation	1	5.65	2.84	1.29	.205
	2	4.33	2.18		
Physcial Comfort	1	2.41	1.94	-2.17	.036
	2	4.00	2.00		
Satisfaction	1	2.50	.71	.60	.552
	2	2.33	.87		

T^2-35.91 F=2.47 df=11, 31 SIG=.024

[b]Group 1- Professional Staff (N=34) Group 2= Clerical Staff (N=9)

TABLE 5

Effects of Salary[c] on Dependent Variables

Dependent Variables		Mean	S.D.	T	Pooled Variance Est. 2-Tail Prob.
Involvement	Group 1	7.43	1.50	1.32	.195
	2	6.82	1.53		
Peer Cohesion	1	7.05	2.13	1.92	.061
	2	5.73	2.35		
Staff Support	1	7.33	2.11	2.84	.007
	2	5.32	2.51		
Autonomy	1	7.67	1.59	2.04	.048
	2	6.45	2.24		
Task Orientation	1	4.71	2.03	-1.66	.104
	2	5.68	1.78		
Work Pressure	1	5.24	2.43	.26	.793
	2	5.05	2.36		
Clarity	1	3.90	1.70	.41	.681
	2	3.64	2.46		
Control	1	2.29	1.59	-3.42	.001
	2	4.41	2.38		
Innovation	1	5.81	2.82	1.02	.313
	2	4.95	2.66		
Physical Comfort	1	3.00	2.24	.80	.428
	2	2.50	1.85		
Satisfaction	1	2.24	.70	-2.05	.047
	2	2.68	.72		

T^2=37.32 F=2.57 df=11, 31 SIG=.019

[c]Group 1- above median Salary (N=21) Group 2- below median Salary (N=22)

TABLE 6

Selected Correlations

	Experience						
	# Years MH	#Years Taz.	Education	Salary	Satisfaction	Program[a]	Sex
Involvement	.42*	.39*	.34*	-.20	-.32*	-.15	-.01
Peer Cohesion	.35*	.33*	.15	-.29*	-.45*	.13	.05
Staff Support	.38*	.55*	.11	-.40*	-.28*	.21	.11
Autonomy	.41*	.35*	.26*	-.30*	-.18	.09	.07
Task Orientation	-.06	.01	.07	.25	-.24	-.06	-.07
Work Pressure	.15	-.12	.26*	-.04	.21	.12	-.02
Clarity	-.04	.06	-.32*	-.06	-.14	.14	.08
Control	-.42*	-.40*	-.38*	.47*	.14	.07	.12
Innovation	.34*	.27*	.13	-.16	.02	-.10	.10
Physical Comfort	.05	.21	-.17	-.12	-.49*	.16	.00
Salary	-.67*	-.50*	-.43*	____	____	-.03	.16
Satisfaction	-.26*	-.17	-.19	.31*	____	-.08	-.07

* $p \leq .05$

[a] For purposes of analyses staff were categorized as being in one of seven programs at the center.